Patient_____

Address_____

Insurance Carrier_____

Attorney (if applicable)_____

Do you have Medicare? _____ Yes _____ No

Assignment of Payment

My insurance carrier and/or attorney are here by requested and authorized to pay directly to **Hammer Chiropractic, LLC.** for any service rendered and/or the same to be deducted from any settlement made on my behalf for services on my account.

Further, I agree to pay **Hammer Chiropractic, LLC.** the difference, if any, of the agreement between insurance carrier and my attorney and/or myself. It is my responsibility to pay any deductible, coinsurance, and supplies in the aforementioned agreement. It is further understood that I, the undersigned agree to pay **Hammer Chiropractic, LLC.** the full amount of his charges should my condition be such that it is **NOT** covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Hammer Chiropractic, LLC. will file the billing information in a timely manner, unless otherwise instructed by the patient or primary insured.

Furthermore, I have read the information regarding office policy on Insurance Assignment and Payment Policies for Hammer Chiropractic, LLC. and fully understand my responsibilities for payment.

Date_____

Signed_____(Patient/Parent)

Witness_____

12% annual interest charges on all accounts over 60 days
$20 Charge on all returned checks including NSF and stop payment